THE MAINE CENTER FOR DISEASE CONTROL AND PREVENTION

MAINE EPI-GRAM

THE DIVISION OF INFECTIOUS DISEASE

As part of the legislation passed last session to create the new Department of Health and Human Services (DHHS), the Bureau of Health was renamed the Maine Center for Disease Control and Prevention (Maine CDC). The federal Centers for Disease Control and Prevention will be referenced as "CDC".

The purpose of the Epi-Gram is to distribute timely and science-based information to guide Maine's healthcare professionals in issues of public health and infectious disease importance and to promote statewide infectious disease surveillance.

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Public Health Law In Maine

The recent specter of bioterrorism and a global pandemic has led to a review of our state of emergency public health preparedness. Essential to sound planning is an understanding of emergency public health law in Maine, the extraordinary power it vests in public officials and the practical limitations of public health law. This article is intended to summarize present Maine public health law. To place the law in context, a recent pulmonary tuberculosis case which required involuntary treatment will be discussed. This case demonstrates that, notwithstanding the Department's statutory authority to impose public health countermeasures, practical limitations compromise the ability of the Department to implement necessary long-term involuntary treatment interventions in order to protect public health.

Case Description

A 52 year old homeless, US-born male was treated for smear positive pulmonary tuberculosis in another state early in 2005. At the time of diagnosis, the infecting organism was sensitive to standard four-drug therapy. The individual was hospitalized for two months. Five days after discharge from inpatient care, he was lost to follow up.

The individual arrived in Maine in November of 2005 and lived in a homeless shelter for six months. His TB status was not known until he became symptomatic and was found to have a recurrence of smear positive pulmonary TB, this time INH resistant. He was hospitalized for two months and declared that he would be unlikely to continue his treatment for tuberculosis once he left the hospital. Mental status assessments found the individual to be competent to make informed health care decisions.

A contact investigation was conducted and more than two hundred exposed persons were identified. Transmission of single drug resistant TB was found among six contacts and treatment for latent tuberculosis

infection was initiated for these contacts. To date, 73% of the contacts have been located and evaluated. Efforts to locate and screen the remaining contacts are continuing.

Because the case had made statements indicating an intent to leave Maine, a court order compelling treatment was obtained. The court ordered that the individual receive treatment in the “least restrictive setting” rather than in a secure setting. He was therefore discharged from the hospital to a nursing home and provided with intensive nursing and mental health case management. After eight days, he eloped from the treatment setting and a court order was issued for his arrest.

The case was arrested after three days and held by court order in a county jail until a secure treatment setting could be identified. He was subsequently transferred to the Lemuel Shattuck Hospital Tuberculosis Treatment Unit in Boston, where he remains in involuntary treatment.

This situation has been resource intensive with regard to the cost of medical care for both the case and his contacts. Preventing further transmission of TB from this individual to the community has required an enormous investment in human resources.

The legal challenges presented by this difficult case informs future efforts to identify a means by which a noncompliant case of infectious disease may be isolated until no longer a threat to the public’s health.

Summary of Maine Public Health Authority

The Maine Center for Disease Control and Prevention, Department of Health and Human Services (“Maine CDC”), is the lead state agency responsible for emergency public health preparedness. The Center has broad authority, in the event of a public health emergency, to establish and implement procedures to identify persons exposed to communicable diseases or toxic agents, and impose appropriate educational, counseling or treatment programs to prevent the transmission of communicable disease. 1 It may designate facilities appropriate for the quarantine, isolation and treatment of persons exposed or at significant risk of exposure to communicable or environmental disease or toxic agents and seek court orders to secure involuntary disease control measures. 2 The Department may impose administrative emergency public health orders3, exclude infected persons from school4, and conduct investigations necessary to address any public health threat.5 With approval from the Attorney General, it may issue administrative subpoenas to access health information relevant to any public health threat. 6 If necessary to avoid a clear and immediate public health threat, it may obtain ex parte orders to place individuals into emergency temporary custody7 and seek court ordered public health measures to compel individuals to participate in medical examinations, health counseling, treatment, quarantine, isolation, and other public health measures.

Extreme Public Health Emergencies

In the event the Governor declares an extreme public health emergency[8], the Department has enhanced powers necessary to collect additional health information from medical providers, pharmacists, veterinarians and medical laboratories and place persons into prescribed care[9], including involuntary examination, vaccination, treatment, quarantine and isolation. During such periods, the Department may impose prescribed care upon individuals without court order for up to 48 hours if necessary to prevent disease transmission. Persons subject to prescribed care orders have limited rights of appeal and must remain in custody unless their appeals are granted.

History of Public Health

The principal source of public health legal authority is the police power, traditionally defined as the inherent authority of all sovereign governments to adopt laws and regulations necessary to safeguard public health, safety and welfare. During the 19th century, responsibility for public health was located primarily at the municipal level of government. Local health officials exercised extraordinary power to control persons and property under the legal doctrine *salus populi suprema lex* (the safety of the people is the supreme law). In 1905 the Supreme Court, in upholding the right of a city to compel its citizens to be inoculated for smallpox, emphasized that the public good transcended individual liberty:

There are manifold restraints to which every person is necessarily subject for the common good. …Society based on the rule that each one is a law unto himself would soon be confronted with disorder and anarchy. …This Court has recognized…it is a fundamental principle that persons and property are subjected to all kinds of restraints and burdens, in order to secure the general comfort, health, and prosperity of the State.

In 1917 the Legislature, responding to the need to centralize responsibility for public health preparedness, consolidated responsibility for public health preparedness in the Department of Public Health, the forerunner of Maine CDC. Today Maine CDC bears primary responsibility for public health preparedness in Maine, but relies upon the State's local health officers and municipal health departments, regional emergency management organizations, and the state's hospitals and health practitioners to develop sound public health policy for Maine.

Constitutional Restrictions

Government may not subject persons to involuntary public health measures unless it has demonstrated by clear and convincing evidence, the highest civil burden of proof in the civil law, that involuntary countermeasures are necessary to protect the public from imminent serious harm, and there are no less restrictive treatment alternatives available. Courts will review the constitutionality of involuntary interventions under the three part test adopted by the Supreme Court in *Matthews v. Eldridge,* 424 U.S. 319 (1976): (1) the extent to which the private interest will be affected by public action; (2) the risk of erroneous deprivation of such interest through the procedures used and the value of

probable value of additional procedural safeguards, and (3) the Government's interest, including the intervention involved, and the fiscal or administrative burdens which additional procedural requirements would entail. Although there is no "surefire litmus test by which the quality of a given subset of procedures can be measured with assurance", the propriety of a public health measure will be gauged by the present threat to public health, its potential for disease transmission, the availability of appropriate countermeasures, and the availability, if any, of less restrictive alternatives to protect public health.

Resource Limitations

Although the Maine CDC public health powers are considerable, they are subject to practical limitations. In the case of the drug resistant tuberculosis case, the Department realized that its legal authority was circumscribed by Maine statute and resource limitations. Although Maine law authorized the Department to seek an arrest warrant to pick up the patient after he eloped from a non-secure residential placement, questions arose regarding the Department's authority to place the patient in the Cumberland County Jail, when no other viable residential placement was available. Although the Legislature has not allowed the Department to use county jails as residential facilities in its public health emergency planning, the Court ruled that it had inherent authority to incarcerate an individual who defied a lawful order of court for involuntary residential care. However, the Court realized that jail was only a short-term option and required the Department to develop an appropriate long-term placement. After the Department determined that there were no appropriate in-state, long-term treatment facilities, it made arrangements to place the patient in the tuberculosis unit at Shattuck Hospital. However, the Cumberland Sheriff raised legitimate questions regarding his authority to use force to detain the patient in the event the patient attempted to escape from official custody while out-of-state and en route to the residential placement. Accordingly, the Department is preparing legislation which will facilitate the execution of arrest warrants for patients in violation of involuntary residential treatment orders, and will clarify the authority of law enforcement officers to transport such patients to out-of-state residential placements, if necessary.

Summary

Maine CDC has legal authority to impose such public health countermeasures as are necessary to prevent the imminent spread of communicable disease or environmental conditions which pose a serious threat to public health. It may briefly detain people to prevent disease transmission and secure court orders for examination, vaccination, treatment, residential care, or isolation and, in periods of declared extreme public health emergency, subject persons to involuntary prescribed care measures for up to 48 hours without court order. The Department's authority to exact such involuntary prescribed care measures is grounded in the police power, and is subject to substantive due process constitutional restrictions. Moreover, the Department's discretionary authority is further restricted to the extent the State lacks

suitable secure residential treatment facilities for those persons who require extended treatment. Obstacles towards executing arrest warrants against persons in defiance of lawful court orders, and transporting patients to suitable out-of-state facilities will be addressed by legislation to be offered by the Department at the upcoming legislative session. Thus, although Maine CDC has extensive public health authority, the extent to which it may exercise its authority is contingent upon the resources allocated by the Legislature to provide for long-term involuntary treatment of persons in order to protect against disease contagion.

1 22 M.R.S.A. §807
2 *Ibid.*
3 22 M.R.S.A. §804(2)
4 22 M.R.S.A. §806
5 22 M.R.S.A. §808(1)
6 22 M.R.S.A. §808(2)
7 22 M.R.S.A. §810
8 *Ibid.*
9 An *extreme public health emergency* is defined as "the occurrence or imminent threat of widespread exposure to a highly infectious or toxic agent that poses an imminent threat of substantial harm to the population of the State". *22 M.R.S.A. §801(4-A).*
10 The term *prescribed care* refers to isolation, quarantine, examination, vaccination, medical care or treatment ordered by either the Department or by a court in a period of declared extreme public health emergency. *22 M.R.S.A. §801(8-A).*
11 22 M.R.S.A. §820 (3)

Contributed by Paul Gauvreau and Suzanne Gunston

Revised CDC Recommendations for HIV Testing

This past September, the U.S. Centers for Disease Control and Prevention (CDC) released *Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings*. These recommendations offer guidance for provision of HIV testing in public and private health care settings, including hospital emergency departments, urgent care clinics, inpatient services, substance abuse treatment clinics, public health clinics, and primary care settings. The recommendations do not apply to non-clinical HIV testing (such as testing performed at community-based organizations or during field outreach to at-risk persons).

The primary objectives of these recommendations are to increase HIV screening of patients, including pregnant women, in health care settings; foster earlier detection of HIV infection; and reduce perinatal transmission of HIV in the United States.

To meet these objectives, CDC now recommends that voluntary HIV

screening be routinely conducted for all patients aged 13-64 years in all health care settings. Screening should occur after notifying the patient that screening will be done unless the patience declines (commonly known as “opt-out” screening). It is recommended that persons at high risk for HIV infection be screened for HIV at least annually, and that screening be included in the routine panel of prenatal tests for all pregnant women. The recommendations indicate that separate written consent for opt-out HIV screening is not needed, since general consent for medical care is considered sufficient to encompass consent. Finally, prevention counseling is not recommended as part of routine HIV screening programs in health care settings. Previously, CDC had recommended routine screening only for certain high-risk groups.

The new recommendations state that routine, universal patient screening is warranted for many reasons: HIV infection is a serious health disorder that can be diagnosed before symptoms develop; HIV can be detected by reliable, inexpensive, non-invasive screening tests; if HIV is detected in pregnant women, medication can be administered to block perinatal infection; infected patients have years of life to gain if treatment is initiated early, rather than after symptoms develop.

Implications for Maine

Between 1,500 and 1,600 Maine residents are infected with HIV, and approximately 50 new HIV diagnoses are reported annually to Maine CDC. HIV/AIDS remains the 7th leading cause of death for persons aged 20 to 44 years in the state. CDC estimates that up to 30% of people living with HIV remain unaware of their infection.

It is important to note that Maine’s HIV testing laws currently require that face-to-face pre- and post-test counseling be offered to patients who are tested for HIV. Maine law also stipulates that written, informed consent be obtained before patient testing is performed. "Opt-out” testing as recommended by CDC is therefore not currently allowable under Maine law. Certain other portions of the recommendations, such as expanded, routine patient testing, could be implemented.

Maine health care providers should continue to obtain written, informed consent from patients, and should offer pre- and post-test counseling. Only those portions of the CDC recommendations allowable under Maine law should be implemented at this time. During the coming months, Maine CDC will work with health care providers and community stakeholders to explore changing existing laws in order to better implement the new recommendations.

Resources

The full text of the CDC ***Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health Care Settings*** can be found at the following Internet address: http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5514a1.htm

Contributed by Mark Griswold

2006 Epidemiology Recognition Awards

The Division of Infectious Disease, Maine Center for Disease Control and Prevention has the pleasure of announcing the recipients of the 15th Annual Public Health epidemiology Recognition Awards. The recognition awards are presented to members of the health care community who work above and beyond the call of duty to promote public health surveillance within their communities throughout the year. The awards were given during the Division of Infectious Disease's Annual Infectious Disease Symposium, "Emerging Infectious Diseases in Maine: The Public Health Response," held in Augusta on November 14, 2006.

The recipients of this year's awards were Paul Gauvreau, Assistant Attorney General, Office of the Attorney General; Jim Lysen, Director B Street Clinic, Lewiston; Peggy Mc Rae, RN, Critical Care and Emergencies, Central Maine Medical Center; Lewiston; and Gena Wilson, MD, Lewiston. The award consists of a certificate with the image of the "Broad Street Pump," implicated as the source of infection by John Snow in his classic investigation of an 1854 cholera epidemic in London. Almost one and one-half centuries later, it remains clear that by striving to improve, promote and maintain an active disease surveillance system, the health of Maine citizens will be better protected.

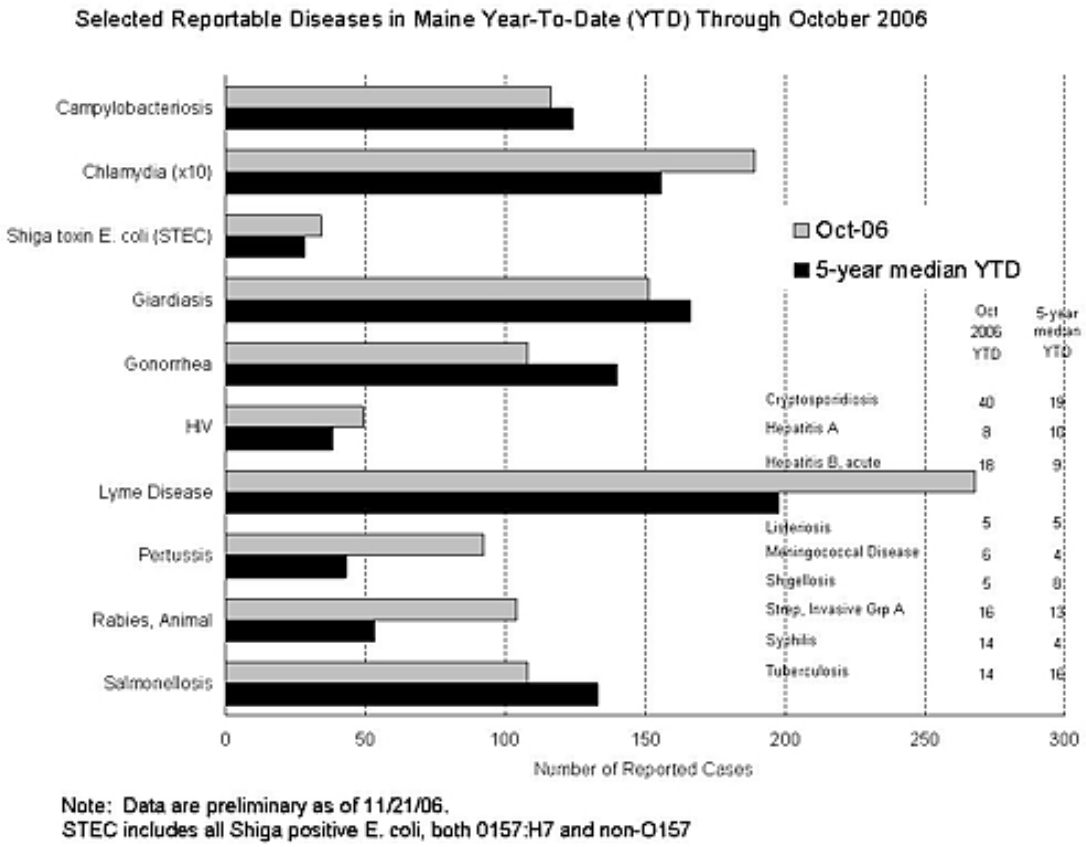
The staff of the Division of Infectious Disease congratulates the recipients of this year's award for these exemplary efforts in promoting and protecting the public health of Maine's citizens.

Jim Lysen, B Street, Lewiston; Kathleen F. Gensheimer, MD, MPH, Division of Infectious Disease; and Paul Gauvreau, Assistant Attorney General, Augusta (not pictured: Gena Wilson M.D., Central Maine Medical Center and Peggy Mc Rae, R.N., Central Maine Medical Center)

Contributed by Kathleen F. Gensheimer

Selected Reportable Diseases in Maine Year-to-Date (YTD) - Through October 2006

Click on this line or on the image below to see it full-size.



Note: Data are preliminary as of 11/21/06.
STEC includes all Shiga positive E. coli, both 0157:H7 and non-O157

Contributed by Amy Robbins

Please call Maine CDC to report all reportable diseases

Telephone Disease Reporting Line:
24 hours / 7 days
1 800 821-5821

Consultation and Inquiries:
24 hours / 7 days
1 800 821-5821

Facsimile Disease Reporting Line:
24 hours / 7 days
1 800 293-7534

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